General Assembly **Substitute Bill No. 16**

January Session, 2011 *____SB00016APP__051111___*

AN ACT CONCERNING STANDARDS FOR HEALTH CARE PROVIDER CONTRACTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subparagraph (B) of subdivision (15) of section 38a-816 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(B) Each insurer, or other entity responsible for providing payment to a health care provider pursuant to an insurance policy subject to this section, shall pay claims not later than **[**forty-five**]** (i) sixty days after receipt by the insurer of the claimant's proof of loss form in paper format or the health care provider's request for payment in paper format filed in accordance with the insurer's practices or procedures, or (ii) fifteen days after the claimant or health care provider has electronically filed a claim or request for payment, except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477, the insurer shall **[**(i)**]** (I) send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than thirty days after the insurer receives a claim for payment or reimbursement under the contract, and **[**(ii)**]** (II) pay claims for payment or reimbursement under the contract, for a claim or request that was filed in paper format, not later than thirty

days after the insurer receives the information requested, and for a claim or request that was filed electronically, not later than fifteen days after the insurer receives the information requested.

Sec. 2. (NEW) (*Effective January 1, 2012*) The Insurance Commissioner shall establish procedures to be used by insurers, health care centers, fraternal benefit societies, hospital service corporations, medical service corporations or other entities delivering, issuing for delivery, renewing, amending or continuing an individual or group health insurance policy or medical benefits plan in this state providing coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes for the (1) solicitation of health care providers, as defined in section 38a-478 of the general statutes, to participate in provider networks of such entities, and (2) maintenance of provider participation in such networks.

Sec. 3. (NEW) (*Effective January 1, 2012*) Each insurer, health care center, managed care organization or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy or medical benefits plan, or preferred provider network, as defined in section 38a-479aa of the general statutes, that contracts with a health care provider, as defined in section 38a-478 of the general statutes, for the purposes of providing covered health care services to its enrollees, shall maintain a network of such providers that is consistent with the standards established by the National Committee for Quality Assurance's Managed Behavioral Healthcare Organization Standards and Guidelines for quality management and improvement.

Sec. 4. Subdivision (1) of subsection (a) of section 38a-226c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(1) Each utilization review company shall maintain and make available procedures for providing notification of its determinations regarding certification in accordance with the following:

(A) Notification of any prospective determination by the utilization review company shall be mailed or otherwise communicated to the provider of record or the enrollee or other appropriate individual within two business days of the receipt of all information necessary to complete the review, provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing. After a prospective determination that authorizes an admission, service, procedure or extension of stay has been communicated to the appropriate individual, based on accurate information from the provider, the utilization review company may not reverse such determination if such admission, service, procedure or extension of stay has taken place in reliance on such determination.

(B) Notification of a concurrent determination shall be mailed or otherwise communicated to the provider of record within two business days of receipt of all information necessary to complete the review or, provided all information necessary to perform the review has been received, prior to the end of the current certified period and provided any determination not to certify an admission, service, procedure or extension of stay shall be in writing.

(C) The utilization review company shall not make a determination not to certify based on incomplete information unless it has clearly indicated, in writing, to the provider of record or the enrollee all the information that is needed to make such determination.

(D) Notwithstanding subparagraphs (A) to (C), inclusive, of this subdivision, the utilization review company may give authorization orally, electronically or communicated other than in writing. If the determination is an approval for a request, the company shall provide a confirmation number corresponding to the authorization.

(E) If a utilization review company makes a prospective or concurrent determination to authorize or certify an admission, service, procedure or extension of stay, regardless of whether such authorization or certification is required or is requested by an

enrollee's provider, no such utilization review company or insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity responsible for paying claims shall refuse to pay for such admission, service, procedure or extension of stay if such admission, service, procedure or extension of stay has taken place in reliance on such determination.

[(E)**]** (F) Except as provided in subparagraph **[**(F)**]** (G) of this subdivision with respect to a final notice, each notice of a determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) the procedures to initiate an appeal of the determination or the name and telephone number of the person to contact with regard to an appeal pursuant to the provisions of this section, and (iii) the procedure to appeal to the commissioner pursuant to section 38a-478n.

[(F)**]** (G) Each notice of a final determination not to certify an admission, service, procedure or extension of stay shall include in writing (i) the principal reasons for the determination, (ii) a statement that all internal appeal mechanisms have been exhausted, and (iii) a copy of the application and procedures prescribed by the commissioner for filing an appeal to the commissioner pursuant to section 38a-478n.

Sec. 5. (NEW) (*Effective January 1, 2012*) No insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing an individual or group health insurance policy in this state providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes that preauthorizes or precertifies an admission, service, procedure or extension of stay through other than a utilization review company, as defined in section 38a-226 of the general statutes, shall reverse such preauthorization or precertification or refuse to pay for such admission, service, procedure or extension of stay, if such

admission, service, procedure or extension of stay has taken place in reliance on such preauthorization or precertification. The provisions of this section shall apply regardless of whether such preauthorization or precertification is required or is requested by an enrollee's health care provider.

Sec. 6. (NEW) (*Effective January 1, 2012*) (a) No contract between an insurer, health care center, fraternal benefit society, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing an individual or group dental plan in this state and a dentist licensed pursuant to chapter 379 of the general statutes shall contain any provision that requires such dentist to provide services or procedures at a set fee to such entity's insureds or enrollees, unless such services or procedures are covered benefits under such insured's or enrollee's dental plan.

(b) The provisions of this section shall not apply to (1) a self-insured plan that covers dental services, or (2) a contract that is incorporated in or derived from a collective bargaining agreement or in which some or all of the material terms are subject to a collective bargaining process.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2012*	38a-816(15)(B)
Sec. 2	*January 1, 2012*	New section
Sec. 3	*January 1, 2012*	New section
Sec. 4	*January 1, 2012*	38a-226c(a)(1)
Sec. 5	*January 1, 2012*	New section
Sec. 6	*January 1, 2012*	New section

INS *Joint Favorable Subst.*

APP *Joint Favorable*